GEORGIA GNI NEUROSURGICAL Institute
BRAIN & SPINE SPECIALISTS

Authorization to Disclose Protected Information

The undersigned authorizes Georgia Neurosurgical Institute
840 Pine Street Suite 880 Macon, GA 31201
P: 478-743-7092 F: 478-743-6293
to release my health information as noted below. ***Please review carefully.***

Patient Information

Patient's Full Name: _____

Other Names: _____

Patient Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Phone: _____

Release Information to:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Patient's Email: _____ *(Please ensure email is legible)*

Information to be Released

If you fail to specify a 1 year abstract will be provided

- ☐ Please release 1 year abstract of my records (includes most recent notes, labs, & testing)
- ☐ Please release a 2 year abstract of my records
- ☐ Please release my entire record.
- ☐ Other (please specify): _____

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. * _____ ***(Please Initial)***

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____, If not expiration is not specified this authorization expires in 90 days
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulation and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety- if form is incomplete, or if protected information is not released, we may be unable to fulfill this request

Signature: _____ Date: _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*